## LAWRENCE COUNTY SCHOOLS

## ASTHMA IHP/SAFETY PLAN-PRESCRIPTION MEDICATION ORDERS

***This portion is completed by the Physician/Healthcare Provider and when signed may serve as medication authorization.***

**Student Name:** _____ **DOB:** _____

ASTHMA RISK: Mild _____ Moderate _____ Severe _____

Pretreatment for strenuous activity: ☐ Not Required

Pretreatment for strenuous activity: ☐ Routinely OR ☐ Upon request of student/parent/guardian

Pretreatment Medication/Dose: _____

**Protocol/Procedure for student having an Asthma Attack:**

1. Encourage student to remain calm, take slow, deep breaths, and sit upright.
2. Stop physical activity.
3. Allow student to administer prescribed asthma medication (if available):
   Medication/Dose: _____
   If a quick relief inhaler or action plan is not available, send to the clinic accompanied by a staff member or peer.
4. Stay with student and monitor response.
   - If symptoms decrease in 15 minutes and the student is relieved, he/she may return to class. Contact school nurse for assessment of therapeutic effects of medication administration.
   - If symptoms persist after 15 minutes contact the school nurse, call parent, and PROCEED TO EMERGENCY ACTION PLAN BELOW.

**EMERGENCY ACTION PLAN (Medication is not helping or is unavailable, breathing hard and fast, nose opens wide, trouble speaking, ribs showing in children, lips or fingernails blue, etc.):**

1. **If in doubt, activate EMS/Call 911.**
2. Stay with the student and continue to monitor breathing and general condition.
3. Allow student to take additional prescribed, rescue medications or doses as ordered (if available).
4. School Nurse will assess student, utilize pulse oximeter.
5. Call 911 if in doubt, not breathing, unconscious, lips or fingernails are blue, struggling to breathe (hunched over or ribs show, or having any other signs of distress.
6. Notify parent or guardian.

If peak flow meter used, please specify parameter: _____

For Inhaled Medications (Please check ONE of the following):

_____ I have instructed this student in the proper way to use their inhaled medications. It is my professional opinion that he/she should be ALLOWED TO CARRY and use their prescribed inhaler.

_____ It is my professional opinion that the student SHOULD NOT carry his/her inhaled medications, but should receive assistance with administration by an adult.

This child has the following additional chronic illnesses/disabilities: _____

Length of Time Prescribed: _____ Possible Side Effects: _____

Healthcare Provider's Signature: _____ Date: _____

Healthcare Provider's Name (Print): _____ Phone: _____

**Personnel Informed of Care:** ❑ Classroom Teacher(s) ❑ Administration ❑ Special Ed. Teacher ❑ Transportation Staff ❑Cafeteria Personnel

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